

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676042	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/21/2025
NAME OF PROVIDER OR SUPPLIER McAllen Transitional Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2109 South K St MC Allen, TX 78503	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER
REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to establish an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for, 1 of 1 resident (Resident #1) observed for infection control issues in that: CNA A did not follow infection control procedures while providing incontinent care to Resident #1 when she failed to apply a PPE gown prior to providing incontinent care, reused wipes when providing care to the perineal area, and did not sanitize hands between glove changes. This deficient practice could place residents at-risk for infection due to improper PPE, sanitizing hands, and incontinent care practices. The findings included: Record review of Resident #1's electronic face sheet dated 11/5/25 revealed the resident was a [AGE] year-old female with an initial admit date to the facility on 7/16/25. Her diagnosis included dementia (a medical condition characterized by a progressive decline in cognitive functions, such as memory, thinking, reasoning, language, and judgement), depression (a common mental health condition characterized by persistent feelings of sadness, hopelessness, and loss of interest), dysphagia (a medical condition characterized by difficulty or discomfort in swallowing), cognitive communication deficit (an impairment in a person's ability to communicate effectively due to underlying problems with cognitive functions like memory, attention, reasoning, and problem-solving), nontraumatic intracerebral hemorrhage (a type of stroke involving bleeding within the brain's tissue that was not caused by a physical injury), unspecified convulsions (sudden, involuntary muscle contractions or spasms where the exact type or cause was not identified), muscle weakness, muscle wasting and atrophy (decrease in size or wasting away of muscle). Record review of Resident #1's Quarterly MDS assessment dated [DATE] reflected Resident # 1 had a BIMS score of 10 which indicated moderate cognitive impairment and was dependent for all ADL care. Record review of Resident #1's undated comprehensive person-centered care plan, reflected Resident #1 had: ADL Self Care Performance Deficit r/t Weakness. Dx. CVA w/Lt. Hemiplegia. intracranial hemorrhage, dementia. TOILET USE (TOILET TRANSFER, TOILET HYGIENE): requires assistance to: wash hands, adjust clothing, clean self, transfer onto toilet, transfer off toilet, to use toilet. Date Initiated: 07/17/2025. Had Indwelling Catheter. Catheter type: FR # 18 mL _ to closed urinary drainage system - diagnosis for use: neurogenic bladder Date Initiated: 07/17/2025. Use Enhanced Barrier Precautions Date Initiated: 07/24/2025. Requires tube feeding Glucerna 1.5 AT 50 ML/HR X 22 hr, 200ml water q 4 hours Date Initiated: 07/17/2025. Use Enhanced Barrier Precautions Date Initiated: 10/07/2025. Had pressure ulcer or potential for pressure ulcer development r/t Risk for skin integrity. Weakness. Dx. CVA w/Lt. Hemiplegia. intracranial hemorrhage, dementia, DMII. malnutrition, Actual pressure ulcer: stage 3 pressure ulcer to sacrum Date Initiated: 09/09/2025 Created on: 07/17/2025. Use Enhanced Barrier Precautions Date Initiated: 08/31/2025. EBP PPE Risk for infection related to High contact care activity Enhanced Barrier Precautions: PPE required for high resident contact care activities. Indication: indwelling catheter, PEG tube, wounds. Date Initiated: 11/05/2025. Record review of Resident #1's Order Summary Report dated 11/5/25 reflected orders for Enhanced Barrier Precautions: PPE required for high resident contact care activities. Indication: Indwelling catheter, PEG Tube, wounds every shift Active 10/7/2025. During an incontinent care observation for Resident #1 on 11/4/25 at 5:45 PM., CNA A performed incontinent care on Resident #1, LVN B was already in the room and later assisted with repositioning and providing safety for Resident #1, and ADON C was already in the room at the time the need for a brief change was identified and remained in the room. CNA A appropriately washed her hands and donned gloves prior to starting incontinent care. CNA began incontinent care when unfasted the tabs on the brief, opened the diaper forward, when noted Resident #1 had a large BM that entered the vaginal area. CNA A wiped the vaginal area using one wipe per swipe. CNA A did not apply a gown prior to starting incontinent care. CNA A removed her gloves after swiping with the second wipe, then washed her hands with soap and water in the bathroom sink. CNA A returned wearing a gown and clean gloves. CNA A continued to wipe the vaginal area using one wipe per swipe until the vaginal area was cleaned. CNA A would wash her hands with soap and water after every second glove change. CNA A did not sanitize her hands between the other glove changes. CNA began using one wipe per swipe when she cleaned the buttocks area, but after the third wipe CNA folded over each wipe and reused each wipe throughout the remainder of the incontinent care. In an interview on 11/4/25 at 6:20 pm CNA A stated they received skills check-off and/or training on incontinent</p>		